# LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

**Mailing Address: 7500 Odawa Circle, Harbor Springs, MI 49740**
**Physical Address: 915 Emmet Street, Petoskey, MI 49770**
**Phone: (231) 242-1620 / Fax: (231) 242-1635**

## CHILDCARE ASSISTANCE
## OVERVIEW

### I. PURPOSE

The sole purpose of this program is to assist eligible parents with child care expenses so they can begin/continue in an approved educational plan or in productive employment or employment training.

### II. GENERAL REQUIREMENTS

1. Children must be under the age of 13.

2. Child must reside in the proposed service area: Charlevoix, Cheboygan, and Emmet counties.

3. Child's parent must be a member, or eligible for membership of a federally recognized tribe or a member of a Michigan historic tribe. (Tribal Identification and membership cards are required.)

4. Child's parent must be employed or enrolled in a job training or education program. *(Require copies of 1 month's earnings; official class schedule; and grant and scholarship award letters)*

### III. INCOME ELIGIBILITY & PAYMENT ASSISTANCE

Eligibility criteria are based on a family's monthly gross income and shall not exceed the maximum allowed income for individual family size. The percentage paid by the Tribe shall be determined by eligible household gross income.

### IV. SELECTION OF DAY-CARE PROVIDERS

1. The applicant shall select the Provider(s) needed for day care assistance. More than one (1) Provider may be used; however, Provider selected must be at a minimum, 18 years of age.

2. Selected Day Care Centers and Family/Group Home Providers must be licensed by the State of Michigan. A copy of Provider's current License is required at time of application. *(A copy of all renewed licenses must be submitted within 10 days of re-issuance).*

3. All providers must sign the **Provider Statement of Agreement**, complete a W-9 Form *(Required at time of application)* and must be in agreement to 2 annual random home visits by personnel from the Human Services Department.

4. Applicant MUST complete and submit a **CHANGE OF INFORMATION FORM** for all changes made to the initially approved application *(i.e. Provider change and/or addition or deletion of eligible children).* Parent's bear the responsibility of payment for services rendered by an unapproved Provider.

### V. DAY CARE RATES, TIME SHEETS & PAYMENT SCHEDULES

| | Day Care Centers | | Family/Group Home | | Relative Care | |
|---|---|---|---|---|---|---|
| **AGE** | Charlevoix/ Emmet | Cheboygan | Charlevoix/ Emmet | Cheboygan | Charlevoix/ Emmet | Cheboygan |
| 0 to 2 ½ yrs | $2.98 | $2.60 | $2.08 | $2.08 | $1.95 | $1.95 |
| 2 ½ years to 12 | $2.33 | $2.08 | $2.08 | $2.08 | $1.95 | $1.95 |

1. Both the Parent/Guardian and Provider are responsible for accurately documenting hours on timesheets.
2. The Parent shall be the responsible party for insuring that time sheets are submitted in required time frames.
3. Checks will be made payable to provider only and shall be mailed directly to the Provider.

# CHILDCARE ASSISTANCE
# APPLICATION FOR SERVICES

**Please complete application thoroughly and submit all required documentation. All information contained in this application is treated confidentially and no information will be revealed to anyone without the express written consent of the applicant.**

**Date:** _____

**Name:** _____

**Address:** _____

**Apt. No.:** _____

**City/MI/ Zip** _____

**County:** ☐**Emmet** ☐**Charlevoix** ☐**Cheboygan**

**Tribal Affiliation** _____

**Enrollment No.** _____

**Date of Birth** / /

**Social Security #** - -

**Home Telephone** ( )

**Work Telephone** ( )

**Relationship to child/ren:** ☐**Parent** ☐**Foster Parent**

***If Foster Care, attach copy of Court Order Placement***

***Please complete if Mailing Address is different from Physical Address:***

_____ _____

**Address** **City/State/Zip**

**REASON FOR CHILD CARE:** ☐Employment ☐School ☐Training

## CHILDCARE NEEDS

List the children's name, age, grade and number of weekly hours needed for childcare services during the school year and during summer.

| Child's Name | DOB | Grade | School Hours | Summer Hours |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## HOUSEHOLD COMPOSITION INFORMATION

*List all "Family Members" other than the applicant, who are living in your household. This includes Spouse, Significant Other, and all other children between the ages of 13 - 18. Include the relationship to the children listed under Childcare Needs. (i.e. Mother, Father, Brother, Sister)*

| **NAME** | **DOB** | **SOCIAL SECURITY** Copies required | **RELATIONSHIP** | **TRIBE/ENROLL #** Copies required |
|---|---|---|---|---|
| **2.** | | | | |
| **3.** | | | | |
| **4.** | | | | |
| **5.** | | | | |
| **6.** | | | | |
| **7.** | | | | |

## HOUSEHOLD INCOME VERIFICATION

******IF YOU ARE A FOSTER PARENT, PROCEED TO PROVIDER INFORMATION SECTION******

**Earned Income** – Beginning with Applicant, list all **earned gross income** for adult "family" members listed in household composition. Attach a copy of past thirty (30) days income, including any tips. If claiming seasonal or self employment, you must attach a copy of latest income tax return.

| NAME | EMPLOYER'S NAME & ADDRESS | Pay Frequency | Monthly GROSS Income | |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | **Total EARNED GROSS Income** | $ | |

**Un-earned Income** – Beginning with applicant, list all **un-earned gross income** for adult "family" members listed in household composition (i.e. social security, retirement/pension, disability, unemployment benefits, child support, per capita payments, education scholarship, etc.) Documentation must be provided for all court ordered child support.

| NAME | SOURCE OF INCOME | Pay Frequency | Amount | Pay Frequency | Monthly Gross Income | |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | **Total UNEARNED Income** | $ | |

**SCHOOL OR TRAINING** *Include verification of registration and class or training schedule. (Must be submitted each semester attending).*

| NAME | SCHOOL | ATTENDING |
|---|---|---|
| | | ☐Spring ☐Summer ☐Fall ☐Winter |
| | | ☐Spring ☐Summer ☐Fall ☐Winter |

## PROVIDER INFORMATION

****Current and valid License(s) for group and center based childcare must accompany application.*** Applicant may have more than 1 provider, however total paid hours cannot exceed 40 hours per week.

| **Type of Care:** | ☐**Relative Care** ☐**In Home** ☐**Group/Home Child Care*** ☐**Center Based*** *Group / Home Child Care and Center Based Child Care require licensing by the State of Michigan | | |
|---|---|---|---|
| **Provider Name:** | | **Provider Name:** | |
| **Address City / Zip:** | | **Address City / Zip:** | |
| **Contact License:** | | **Contact License:** | |
| **Telephone:** | | **Telephone:** | |

## APPLICANT CERTIFICATION

I certify that all the answers given are true, complete and correct to the best of my knowledge. This certification is made with the knowledge that the information will be used to determine eligibility to receive LTBB Childcare Assistance. I agree to report all changes in my household composition and/or household income within 10 days of when the date of change occurred.

| **Signature** | | **Date** | |
|---|---|---|---|

# Rights and Acknowledgements

**1. APPLICATION.** I understand that I have the right to file an application for childcare services. I understand that I must provide all necessary documentation for my application to be considered. Incomplete applications will not be accepted. I understand that I will receive notice regarding my approval or denial of services within 10 days of receipt of a completed application including all supporting documentation from the Human Services Department.

**2. AUTHORIZATION FOR SERVICES.** I understand that I am responsible for all childcare expenses incurred prior to my application being approved and Notice of Approval sent to me. This includes all pre-existing childcare bills that I may have with my childcare provider.

**3. NON-DISCRIMINATION.** The Little Traverse Bay Bands of Odawa Indians Childcare Assistance will not discriminate against any applicant because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If I believe that such discrimination exists I have the right to file a complaint with the Human Services Department.

**4. REPORTING CHANGES**:

A. I agree to report any changes in income, persons living in the home, changes in childcare provider or other circumstances that may affect my eligibility within **10 days** of the date the change occurs. A "Changes or Additions" form must be completed and submitted with every change.

B. I understand that failure to report all changes, especially financial will result in my termination from the program and any outstanding payment will be my sole responsibility.

C. I understand if I have not actively participated in Childcare Assistance for a period of 60 days or more, I will be required to complete a "Reinstatement Form" and provide required documentation.

**5. REPAYMENT OF BENEFIT.** I understand that if I receive more benefits than I am entitled to receive (through my own or the Tribe's error) I must repay any benefits received for which I was not entitled to.

**6. AFFIDAVIT.** I affirm that all the information provided is true and understand that providing false information will result in termination from the program. Deliberate misinformation that results in obtaining benefits to which I am not entitled may result in prosecution.

**7. RELEASE OF INFORMATION.** I hereby give my permission to the Tribe to contact my designated childcare provider to give notice of eligibility; and to contact MI Department of Human Services for purpose of verification of dual participation.

**8. RECORD KEEPING.** I understand that I must document childcare hours on a timesheet on a weekly basis and that I must submit timesheets at a minimum of once monthly, no later than five (5) business days after the last day of that month. Timesheets will only reflect hours for which I am at work, training, or school. The timesheet must document the in and out times for each day that my child is in care. Timesheets must be signed by the parent and the provider and be signed and dated no earlier than the last day services are rendered. I understand that if I fail to adhere to the recordkeeping standards for this program, the Tribe reserves the right to refuse payment for childcare services and/or I may be terminated from the program for failure to comply.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHILDCARE COSTS NOT PAID BY CHILDCARE ASSISTANCE , INCLUDING BENEFITS WHICH MAY HAVE BEEN AUTHORIZED, BUT ARE NOT PAID DUE TO CIRCUMSTANCES WHICH RENDER ME INELIGIBLE OR FOR FAILURE TO COMPLY WITH TERMS STATED IN THE RECORDKEEPING.

**I HAVE READ AND UNDERSTAND THIS FORM.**

SIGNATURE: _____ DATE: _____

**CHILDCARE ASSISTANCE**
**DOCUMENT CHECKLIST**

Thank you for your interest in Childcare Assistance. To insure that your application is processed without delay, it is imperative that your application is complete including all required documents. For your convenience, please use the following checklist as a guide prior to mailing or bringing in your packet for processing.

APPLICANT

- ☐ Completed and Signed 6 page Application
- ☐ Copies of Child Support Court Orders (Receiving and Paying)
- ☐ Copies of Family's Income (Thirty (30) days Earned and Unearned Income documentation)
- ☐ Copies of all Family members Tribal Membership Cards
- ☐ Copies of all Family members Social Security Cards
- ☐ Copies of Foster Care Placement Orders
- ☐ Verification of Registration and Class/Training Schedule

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PROVIDER SECTION:

The next four pages of this application packet are for your childcare provider. Please detach the next four pages and give to your provider for completion.

In order for your application to be processed, we must receive the completed provider agreement.

- ☐ Signed Day Care Provider Statement
- ☐ Completed and signed W-9 (Must include Social Security Number on Form)
- ☐ Copy of State License (where applicable)
- ☐ Completed and signed Request for Central Registry Clearance
- ☐ Completed and signed Authorization for Criminal Background Investigation

If you need of assistance during the application process, please call (231) 242-1620, or stop by the office located at: 915 Emmet Street, Petoskey, MI, and we will gladly assist you in completing your application and/or making necessary copies of documentation.

## CHILDCARE ASSISTANCE
## PROVIDER AGREEMENT

This is an agreement between the Little Traverse Bay Bands of Odawa Indians *(hereinafter referred to as LTBB)* Childcare Assistance, and

_____ *(hereinafter called Provider)* License # _____

To provide childcare services for: _____ *(hereinafter called Parent/Guardian)*

The Provider attests that the Childcare setting for which I am providing services for is a:
☐ In Home ☐ * Group/Home Child Care, ☐ * Center Based
Or attests that s/he is related to the parent or children providing services for and therefore claims: ☐ Relative Care

**If claiming Relative Care, list the relationship here, (ie: mother, father, brother, sister, aunt, grandmother, grandfather):**

_____

The Provider hereby agrees to abide by the childcare standards set forth by the State of Michigan, while providing services for the parent/guardian of the following children:

1. _____ 3. _____
2. _____ 4. _____

The Provider agrees to provide to the parent/guardian the following:

a) Unlimited access to children while in your care;
b) Immediate notification of all problems or concerns regarding children in care;
c) Assurances of a smoke-free environment while children are in your care.

The Provider agrees to abide by Childcare Assistance reporting requirements and agrees to provide the LTBB Human Services Department with the following documents:

a) Copy of current daycare license *(where applicable)**
b) W-9 Form *(signed,, dated and business identification number or social security number provided)**
c) Accurate weekly timesheets *(signed by parent and provider and dated no earlier than the last day services are rendered)*

The Provider agrees to abide by Childcare Assistance mandated annual inspections (twice annually) by providing access to the childcare facility or home by an LTBB Human Services representative.

The Provider understands that upon receipt of weekly timesheets by the Human Services Department, the timesheets will be checked for accuracy and completeness and a determination will be made if parent and/or provider are in compliance with program requirements.

The Provider understands that payment for services rendered will be made payable directly to provider and that a 1099 form will be issued for tax reporting requirements at the end of each year.

The provider understands and agrees that in the event a parent fails to meet program requirements, and is determined to no longer be eligible to participate in the Childcare Assistance, the parent bears the sole responsibility for total payments due for all services rendered by the provider.

The provider understands that payment for services rendered are not covered by LTBB until the parent/guardian has been approved for program participation.

The Little Traverse Bay Bands of Odawa Indians Childcare Assistance operates on limited annual funding and is intended to assist in payment of daycare services for qualified families. Based on program participation, LTBB does not promise or guarantee that funding will be available for duration of entire fiscal year. In the event that program funds become depleted, LTBB will not be liable for any daycare expenses incurred by the program participant.

The provider agrees to abide by the terms listed in this agreement and will not attempt to defraud or, misrepresent any/all service or time reported to the LTBB Childcare Assistance. The provider further understands that LTBB reserves the right to prosecute for misrepresentation and/or fraud.
I understand that if I receive more benefits than I am entitled to receive (through my own or the Tribe's error) I must repay any benefits received for which I was not entitled to.

Provider Signature: _____ Date _____